Nevada State Veterans Home **Section IV**

Physician's Medical Certificate

This Certification is Valid For Three Months Please print

I certify that _____
Last Name First Name Middle initial

requires 24-hour skilled nursing care. _____ _____
Physician's Signature *Date of Exam*

Date of Birth ____/____/____ Age _____ Social Security # _____ - _____ - _____

Male ☐ Female ☐ **Allergies:** _____

_____

Current Diagnosis: _____

_____

Other Pertinent History: (include past medical problems, complaints, etc.)

_____

_____

_____

_____

Hospitalization and operations for past 90 days:

_____

_____

Physical Examination: Height _____ Weight _____

Temperature _____ Pulse _____ Respiration _____ B/P ____/____

Skin Condition/Pressure Areas: Please describe condition, site, stage, etc. _____

_____

_____

Current diet: _____

Significant other positive findings:

_____

_____

Section IV

PHYSICIAN'S ASSESSMENT FOR CARE PLANNING

PLEASE CHECK APPROPRIATE BOXES BELOW

Level of consciousness:

Alert ☐ Yes ☐ No Comments _____

Withdrawn ☐ Yes ☐ No Comments _____

Confused ☐ Yes ☐ No Comments _____

Oriented as to: ☐ Person ☐ Place ☐ Time
Memory Impairment: ☐ Mild ☐ Moderate ☐ Severe
History of wandering behavior, gets lost: ☐ Yes ☐ No
Comments _____

Communication ability:

Can Speak ☐ Yes ☐ No Understands Speech ☐ Yes ☐ No

Can Write ☐ Yes ☐ No Speaks Clearly ☐ Yes ☐ No

Can Hear ☐ Yes ☐ No Understands Writing ☐ Yes ☐ No

Hearing Aide ☐ Yes ☐ No Understands Gestures ☐ Yes ☐ No

Vision: ☐ Adequate ☐ Moderately Impaired ☐ Wears Glasses ☐ Severely Impaired

Personality or behavioral problems: ☐ Yes ☐ No

If yes, please explain _____

Physically or verbally abusive: ☐ Yes ☐ No

If yes, please explain _____

History of alcohol abuse: ☐ Yes ☐ No Explain: _____

History of drug abuse/use: ☐ Yes ☐ No Explain: _____

History of dementia: ☐ Yes ☐ No Explain: _____

History of psychiatric illness: ☐ Yes ☐ No Explain: _____

History of medication or medical non-compliance: ☐ Yes ☐ No

History of falling or injury secondary to falls: ☐ Yes ☐ No

History of: ☐ delirium ☐ confusion ☐ agitation

Section IV

PHYSICIAN'S ASSESSMENT FOR DAILY LIVING ACTIVITIES

PLEASE CHECK APPROPRIATE BOXES BELOW

Bathing
- ☐ Completely independent
- ☐ Needs assistance
- ☐ Needs total assistance

Grooming
- ☐ Completely independent
- ☐ Needs assistance
- ☐ Needs total assistance

Dressing
- ☐ Completely independent
- ☐ Needs assistance
- ☐ Needs total assistance

Feeding
- ☐ Completely independent
- ☐ Needs assistance
- ☐ Must be fed
- ☐ Has swallowing disorder
- ☐ Unable to prepare own meals

Medication
- ☐ Needs assistance
- ☐ Incapable of taking own meds
- ☐ Able to take own medication

Ambulation
- ☐ Can walk _____ yards
- ☐ Can climb stairways
- ☐ Requires wheelchair
- ☐ Requires assistive devices such as cane walker, electric cart, motorized wheelchair prosthesis. *(Circle all that apply)*

Transfer
- ☐ Can transfer to bed, chair, toilet
- ☐ Uses aides for incontinence

Toilet
- ☐ Completely independent
- ☐ Uses aides for incontinence
- ☐ Occasionally wet and soils self
  - ☐ 1 x day ☐ 2 x day ☐ More often

Is this applicant's medical condition such that he/she is capable of conducting his/her own affairs.

Yes ☐ **No** ☐

_____

_____

Physician's Name _____ License No. _____
(please print)

Physician's Signature * _____

Address _____
(Street) (City/State) (Zip)

Telephone (____) _____ Fax (____) _____

Date signed _____

***NOTE:** **If this evaluation is being performed by a physician assistant or nurse practitioner, it must be counter-signed by a Physician/MD.**

FG-1204 E

PHYSICIAN'S PRE-ADMISSION ASSESSMENT

Nevada State Veterans Home
100 Veterans Memorial Drive, Boulder City, NV. 89005
Phone (702) 332-6864 Fax (702) 332-6771

MUST BE SUBMITTED WITH THE PHYSICIAN'S MEDICAL CERTIFICATE

Resident Name_____ Date_____

Primary Diagnosis_____

Secondary Diagnoses_____

DIET (Indicate type)
- ☐ Regular
- ☐ No Added Salt
- ☐ No Concentrated Sweets
- ☐ Gastric Soft
- ☐ Low Fat/Low Cholesterol
- ☐ Tube Feeding - Type: _____

Textures: (Indicate texture)
- ☐ Regular Texture
- ☐ Mechanical Soft
- ☐ Puree
- ☐ Thickened Liquids

OXYGEN: _____Liters Per Minute Frequency_____

MEDICATION PRESCRIPTIONS:

Medication including PRN	Dose	Frequency	Route	Diagnosis

TREATMENTS:_____

_____

ALLERGIES: _____

Folstein Mini Mental State Examination: Score: _____ Date: _____

Is the patient aware of his/her medical condition? ☐Yes ☐No Patient wanders and requires locked or secured neighborhood ☐ Yes ☐ No

Do you prescribe long term care for this patient? ☐Yes ☐No Patient is ☐ able ☐ unable to handle his/her own financial/medical decisions.

Outings ☐ Yes ☐No (We need authorization from the attending physician) the trips are supervised by the NSVH.

Physician's Name_____ **License No.**_____
Please Print

Signature_____ **Telephone**_____ **Fax**_____

Address_____
Street **City** **State** **Zip**

NEVADA STATE VETERANS HOME
QUESTIONNAIRE ON BEHAVIORAL CONCERNS & PSYCHIATRIC HISTORY

APPLICANT NAME:							DATE:
		FREQUENCY					
	BEHAVIORS	NOT IN LAST 6 MONTHS	NOT IN LAST 30 DAYS	UP TO 5 DAYS /WEEK	DAILY	NEVER	COMMENTS
1	Wandering…getting lost						
2	Hiding things (money, jewelry, keys)						
3	Resists necessary care						
4	Hoarding things						
5	Rummaging through others belongings						
6	Being suspicious or accusative						
7	Verbally abusive to others						
8	Seeing people or things that are not there						
9	**Physically aggressive behavior toward self**						
10	**Bangs head on wall, floor or furniture**						
11	**Attempts to bruise or cut self**						
12	**Attempts to throw self on floor**						
13*	**Physically aggressive toward others**						
14*	**Attempts to hit, punch, kick or choke others unprovoked**						
15*	**Attempting to break furniture or glass**						
16*	**Indiscriminately attempting to touch breast, genitals, undress others**						
17*	**Attempting to have non-consensual sexual intercourse with others**						
18	**Exposing self to others**						
19	**Talking about killing self**						
20	**Attempting to eat non food items**						
21	**Voiding or defecating in inappropriate locations**						

PERSON GIVING INFORMATION/RELATIONSHIP _____ PERSON COMPLETING FORM _____ DATE ___/___/_____

NEVADA STATE VETERANS HOME
QUESTIONNAIRE ON BEHAVIORAL CONCERNS & PSYCHIATRIC HISTORY
NARRATIVE NOTES

DATE/TIME	